DISTRICT OF COLUMBIA
DOH OFFICE OF ADJUDICATION AND HEARINGS

DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH Petitioner, v. ANGEL SQUARE and JOYCE OLAYINKA Respondents	Case No.: I-02-90004

FINAL ORDER

I. Introduction

On May 24, 2002, the Government served a Notice of Infraction upon Respondents Angel Square and Joyce Olayinka alleging that they violated 22 DCMR 3801.8, which provides that residents of mental health community residence facilities have the right to "adequate and humane treatment by competent, qualified, professional staff," and 22 DCMR 3823.10, which requires a mental health community residence facility to report and document all medication errors. The Notice of Infraction alleged that the violations occurred on May 13, 2002 at 1253 Morse Street, N.E. It sought a fine of $100 for the alleged § 3801.8 violation and a fine of $500 for the alleged § 3823.10 violation.

Respondents filed a timely answer with a plea of Admit with Explanation to the § 3801.8 charge, and a plea of Deny to the § 3823.10 charge. I held an evidentiary hearing on October 22, 2002. Lynne Riggins appeared on behalf of the Government, accompanied by Leslie deVeau, the inspector who issued the Notice of Infraction. Respondent Joyce Olayinka appeared on her own behalf and on behalf of Respondent Angel Square. Based upon the testimony of the

witnesses, my evaluation of their credibility, and the exhibits admitted into evidence, I now make the following findings of fact and conclusions of law.

II. Findings of Fact

On May 13, 2002, Respondent Angel Square operated a community residence facility for mentally ill persons at 1253 Morse Street, N.E. Respondent Joyce Olayinka is the residence director of the facility.

A. The § 3801.8 Charge

Respondents' plea of Admit with Explanation establishes that they failed to provide treatment at the facility by competent, qualified professional staff. With respect to this charge, the parties have focused upon the qualifications of one staff member who was on duty on May 13, 2002, and who began working at the facility on April 29, 2002.[1] That staff member had received training in CPR at a Red Cross class on April 26, 2001, She received a certificate, which the Red Cross stated it would recognize as valid for one year from the completion date. Respondents' Exhibit ("RX") 204. The Red Cross, therefore, no longer recognized her CPR training as valid on the day she started work. I credit Ms. Olayinka's testimony that she believed that the worker needed to update her CPR training and that the worker had an appointment to do so some time during May. The precise date of that appointment is unclear from the record, although the worker had not received the training by May 13, the date of Ms. deVeau's visit.

[1] The staff member told Ms. deVeau that her first day on the job was April 29. Ms. Olayinka agreed that the worker started during the last week of April, but was unable to provide the specific date. I credit the employee's statement and find that her first day was April 29.

B. The § 3823.10 Charge

Ms. deVeau visited the facility at approximately 3 PM on May 13. She discovered that Ms. Olayinka already had certified in the facility's records that at least one resident had received medication that was prescribed for administration at 8 PM that evening.[2] Ms. Olayinka was not present during Ms. deVeau's visit. She testified that, at 1 PM, she had supervised the administration of the residents' medications that were scheduled for that time and that she mistakenly made an entry in the column for one resident's 8 PM medication. She stated that she immediately recognized her error, but decided not to correct the entry because doing so would require erasures that would "mess the medication book up." Instead, she stated that she told the other staff member of the mistake and instructed her that the resident should receive the medicine at 8 PM, notwithstanding the record entry showing that he already had received it. Thus, the evidence establishes that, on the afternoon of May 13, 2002, at least one resident's records showed the impossible: that he had received medication at 8 PM that day, even though that hour had not yet come to pass.[3]

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[2] The parties disagree about the extent of the inaccuracies in the facility's records. Ms. deVeau testified that the records of every resident showed that the 8 PM medications had been administered, while Ms. Olayinka insisted that she had made a mistake only in one resident's record, and only for one of the four medications he was scheduled to receive at 8 PM. The Government did not offer copies of any records into evidence, while Respondent offered the record of one resident, which appears to show that Ms. Olayinka certified that she supervised the administration of only one of the four scheduled 8 PM medications for that resident. RX 208. In light of the ruling on the scope of § 3823.10, *see* pp. 5-7 *infra,* it is unnecessary to resolve the conflict in the testimony over how many inaccurate entries were made in the facility's records on May 13.

[3] There are several inconsistencies in Ms. Olayinka's testimony concerning this incident. For example, the 8 PM entry that Ms. Olayinka insisted was her initial mistaken effort to record what happened at 1 PM reflects that the resident took his medication. RX 208. The separate entry for 1 PM, however, states that the medication in question was "omitted" at that time. *Id.* In addition, while Ms. Olayinka insisted that she returned to the facility and supervised the administration of medications to all the residents at 8 PM, the other staff member, and not Ms. Olayinka, signed the log attesting that the resident in question took his other three medications. *Id.* While this evidence raises

IV. Conclusions of Law

A. Section 3801.8

Section 3801.8 provides:

> Each resident shall have the right to receive adequate and humane treatment by competent, qualified professional staff.

Respondents' plea of Admit with Explanation establishes that they violated § 3801.8 on May 13, 2002. A violation of § 3801.8 is a Class 3 infraction, punishable by a fine of $100 for a first offense. 16 DCMR 3241.3(g), 16 DCMR 3201. The evidence shows that Respondents knowingly employed a worker with an expired CPR certification.[4] Respondents' explanation that they had arranged for re-training some time during May demonstrates a lack of appreciation for the seriousness of the violation. Simply put, workers who do not have the proper qualifications should not be hired. The rule contains no exception for employees who are not qualified if the facility hopes or expects that they will be qualified soon. Nor was this a good faith oversight about the expiration date of an existing employee's certification. The worker in question was a new hire, whose documentation showed that she was not qualified to begin work. For these reasons, I will impose the full fine of $100 for the violation.

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troubling questions about Ms. Olayinka's credibility, those questions ultimately are not material to the decision in this case.

[4] The certification of the Red Cross that the worker's CPR training would be valid for one year is *prima facie* evidence of the period during which the worker's training would satisfy the requirement that she be "competent." *See DOH v. Newcomb Day Care Center,* OAH No. I-00-40411 at 6-7 (Final Order, January 4, 2002).

B. Section 3823.10

Section 3823.10 provides:

> Each medication error, reaction or adverse response to a medication shall be immediately reported to the resident's physician and documented in the resident's record as well as in an incident report.

The Government contends that the erroneous entry in the resident's record was a "medication error" within the meaning of § 3823.10. Due to the uncertainty about this legal issue, I required the parities to file post-hearing memoranda on that question. After reviewing the parties' memoranda, I conclude that the evidence in this case does not establish that there was a "medication error" as that term is used in § 3823.10.

There is no doubt that Ms. Olayinka made a record keeping error at 1 PM on May 13 when she certified that the resident had received his 8 PM medication. Although serious, that error can not be classified as a "medication error" within the meaning of § 3823.10. That term is more appropriately limited to mistakes in the type, amount or method of administration of a medication.

The regulations do not define "medication error," and it is not immediately apparent that the term extends to documentation errors. In such circumstances, the other terms used in the regulation can be a useful guide to the meaning of the uncertain term "medication error."

> If the legislative intent or meaning of a statute [or regulation] is not clear, the meaning of doubtful words may be determined by reference to their relationship with other associated words and phrases . . . . [A] word may be defined by an accompanying word and ordinarily the coupling of words denotes an intention that they should be understood in the same general sense.

2A N. Singer, *Sutherland's Statutory Construction*, §47:16 (6th ed. 2000). *See Gutierrez v. Ada,* 120 S.Ct. 740, 744 (2000); *District of Columbia v. Estate of Parsons,* 590 A.2d 133, 136-37 (D.C. 1991); *DOH v. Heaton,* OAH No. I-00-40058 at 16-18 (Final Order, January 24, 2001).

Section 3823.10 requires reactions or adverse responses to a medication, along with medication errors, to be reported immediately to the resident's physician, as well as documented in the facility's records, and it is reasonable to look to those terms in an effort to understand whether a documentation error is a "medication error" within the meaning of § 3823.10. Unlike reactions or adverse responses to a medication, it is not apparent that a documentation error, if promptly corrected, requires a physician's attention. Confining the term "medication error" to mistakes in the actual administration of medication is consistent with § 3823.10's apparent purpose that a physician know immediately of problems that arise when a resident receives his or her medication. By contrast, prompt correction of a record keeping error would be a sufficient remedy when such an error occurs. There is no evident purpose for a facility immediately to notify a doctor that it made an entry in the wrong box on a chart, but then corrected it.

Moreover, the regulations contain other provisions requiring a facility's records concerning medications to be accurate. For example, 22 DCMR 3823.9 requires:

> Each dose of medication administered shall be properly and promptly recorded and initialed in the resident's record by the person who administers or supervises the medication.

In addition, 22 DCMR 3821.2(k) requires a facility to have current, signed records of "each medication and treatment given," and 22 DCMR 3821.3 has specific requirements concerning how records are to be made and errors corrected:

> Each entry in the record shall be legible, current, in ink, dated and signed by the transcriber with his or her position identified. Errors shall be corrected by crossing out the incorrect information, but may not be erased.

These specific record keeping requirements support the conclusion that the more general term "medication errors" in § 3823.10 is not applicable to documentation errors. *Busic v. United States,* 446 U.S. 398, 407 (1980) ("more specific statute will be given precedence over a more general one, regardless of their temporal sequence."); *Onabiyi v. District of Columbia Taxicab Comm.,* 557 A.2d 1317, 1319 (D.C. 1989). Because other rules unambiguously address record keeping mistakes, it is not necessary to extend the ambiguous term "medication error" to cover such mistakes. Accordingly, the facility's faulty record keeping does not violate § 3823.10.

I emphasize that nothing in this Order should be interpreted as condoning Ms. Olayinka's conduct. The Government's post-hearing memorandum correctly points out that errors such as this one can jeopardize a resident's safety, because staff members and outside medical personnel alike must rely upon the accuracy of medication records. Inaccurate records can lead to a failure to administer necessary medications or to an overdose. Respondents' concern for the neatness of their records is a wholly insufficient justification for creating such a serious risk, even though their actions did not constitute a "medication error" within the meaning of § 3823.10.

IV. Order

Based upon the foregoing findings of fact and conclusions of law, it is, this _____ day of _____, 2003:

ORDERED, that Respondents are **NOT LIABLE** for violating 22 DCMR 3823.10 as alleged in the Notice of Infraction, and that charge is **DISMISSED;** and it is further

ORDERED, that Respondents are **LIABLE** for violating 22 DCMR 3801.8 as alleged in the Notice of Infraction; and it is further

ORDERED, that Respondents, who are jointly and severally liable, shall pay a total of **ONE HUNDRED DOLLARS ($100)** in accordance with the attached instructions within 20 calendar days of the mailing date of this Order (15 days plus 5 days service time pursuant to D.C. Official Code §§ 2-1802.04 and 2-1802.05); and it is further

ORDERED, that if Respondents fail to pay the above amount in full within 20 calendar days of the date of mailing of this Order, interest shall accrue on the unpaid amount at the rate of 1½ % per month or portion thereof, starting from the date of this Order, pursuant to D.C. Official Code § 2-1802.03 (i)(1); and it is further

ORDERED, that failure to comply with the attached payment instructions and to remit a payment within the time specified will authorize the imposition of additional sanctions, including the suspension of Respondents' licenses or permits pursuant to D.C. Official Code § 2-1802.03(f), the placement of a lien on real and personal property owned by Respondents

pursuant to D.C. Official Code § 2-1802.03(i) and the sealing of Respondents' business premises or work sites pursuant to D.C. Official Code § 2-1801.03(b)(7).

/s/ 02/13/03

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John P. Dean
Administrative Judge